Recommendations of the

# Governor's Advisory Committee

on

# Home Visitation

*March 2019*

MIKE DEWINE
GOVERNOR OF OHIO

www.Governor.Ohio.gov

# Dear Ohioans

When I was a young man, I would often plant maple seeds with my grandfather. In fact, he continued to plant seeds every year up until his death, knowing fully that he may never live to see them grow. Today, my son John taps those very same maple trees to produce syrup for our family to enjoy.

Much like my grandfather planted those maple seeds many years ago, we must plant the seeds to ensure that our families and children are strong and healthy for years to come. I believe that evidence-based home visiting is that seed. Ohio's evidence-based home visiting program uses three rigorously tested models to help at-risk families and children find stability and meet developmental milestones.

Home visiting is a two-generational approach, or one that supports parents as well as children. Home visitors can improve the lives of parents by reducing parent stress, improving parenting skill, and helping parents overcome challenges and set and keep goals, like pursuing an education. They also work with children to achieve developmental milestones, such as walking, speech development, and motor skills so that they are ready to learn once they reach kindergarten.

Science has demonstrated that for every dollar invested in certain evidence-based home visiting programs, there is nearly $6 in future returns – fewer children are in need of Individualized Education Plans (IEPs) in school, children are less likely to enter the foster care system, and more children and parents receive the health care they need through a primary care physician, rather than the emergency room. Each of these saves our state and counties money. At the same time, we are building our workforce of the future.

Just 41 percent of children in Ohio arrive at kindergarten with the skills and knowledge they need to succeed in school. Accordingly, it should be no surprise that just 44 percent of Ohioans have an industry-recognized credential or post-secondary degree. If we are going to succeed as a state, we need the skilled workforce that our ever-changing economy requires. This starts with strong children who grow into strong adults. As Frederick Douglass once said, "It is easier to build strong children than to repair broken men." That is why I have made a commitment to serving three times as many families through evidence-based home visiting—so we can grow strong children for today, and for our future.

Very respectfully yours,

Mike DeWine

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## Governor's Advisory Committee on Home Visitation Members

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**Angela Dawson**, director, Ohio Commission on Minority Health
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**Kim Hauck**, chief policy officer, Ohio Department of Developmental Disabilities
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# Introduction

As part of Ohio Governor Mike DeWine's Opportunity for Every Ohio Kid plan, he committed to expanding evidence-based home visiting services to help three times as many families as were being served. On Jan. 15, 2019, his first full day in office, Governor DeWine convened the Governor's Advisory Committee on Home Visitation and tasked them with developing recommendations for reaching that goal. The committee was charged with submitting their recommendations to the Governor by March 1, 2019, and with subsequently publishing a report of their findings.

The advisory committee was made up of 20 individuals with diverse backgrounds in professions including:

- Pediatrics.
- Public health.
- Developmental disabilities.
- Home visitation programming.
- Infant mortality.
- Mental health.

All advisory committee members met on six occasions during the course of seven weeks. Members were also split into three subcommittees — Programming, Evaluation and Efficiency, and Finance— that met twice. Below is a summary of each full-committee meeting.

## Meeting One: Jan. 24

The committee received two presentations – from the Ohio Department of Health and the Ohio Department of Developmental Disabilities. Sandy Oxley, representing the Ohio Department of Health, offered an overview of home visiting basics, addressing specifics on models in place in Ohio, performance standards, and funding. Kim Hauck, representing the Ohio Department of Developmental Disabilities, discussed early intervention basics, including the eligibility requirements of the program. The meeting was concluded with a discussion on goals and next steps.

## Meeting Two: Jan. 30

The committee received three presentations — from the Ohio Department of Health, a family receiving home visiting services, and the Ohio Department of Medicaid. The Ohio Department of Health provided supplemental data that had been requested at the previous meeting. The mother of a 5-year-old boy who received home visiting services told her story and talked about her experience with home visiting. Staff from the Ohio Department of Medicaid discussed the history of the department's role with funding home visiting, targeted outcomes, and infant mortality.

## Meeting Three: Feb. 6

The committee listened to two presentations— one from a family who receives early intervention services and one with updates from the Ohio Department of Health. The family shared their experiences with receiving early intervention services through the PLAY Project. The Ohio Department of Health provided home visiting data by county and provider accessibility. The committee entered an executive session to receive a legal update. The Ohio Department of Health provided an additional presentation on the Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS).

## Meeting Four: Feb. 13

The committee received one presentation from the Commission on Minority Health and began preliminary discussion on recommendations. The Commission on Minority Health and Mansfield Community Hub provided an overview of Ohio's Community HUB Pathways and model. A family perspective was provided to committee members from Latia Houston, who received services from Every Child Succeeds and eventually was hired by the program to serve as a home visitor. Subcommittee reports were shared, and members discussed workforce challenges, family engagement, and other barriers to expanding home visiting services.

## Meeting Five: Feb. 20

Committee members received updates and discussed the draft recommendations of each subcommittee. Evaluation and Efficiency Committee recommendations concentrated on data system reporting and care coordination. Finance Committee recommendations highlighted the need to leverage Medicaid funding. Programing Committee recommendations identified ways to address workforce barriers, increase access to more families, and ensure program alignment.

## Meeting Six: Feb. 27

The committee reviewed and discussed a list of draft recommendations. Discussion was focused on each individual recommendation and improving or clarifying draft language.

The recommendations, captured on pages 15-18, represent consensus from members on content, language and substance.

# Background

Home visiting is a free, voluntary service that provides pregnant women and families with young children with the necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

Brain science is clear that a child's first 1,000 days — roughly from conception to age 2 — lay the foundation for the rest of his or her life. In fact, the brain grows more during this time than at any other point in life. During the first years of life, more than 1 million new neural connections are formed every second.[1] At birth, an infant's brain has a smooth surface, but within nine months, it has many of the same grooved structures as an adult's brain, demonstrating increased complexity.[2] In these important few months, critical parts of the child's brain form, including those controlling vision, hearing, language, and higher order processing (such as attention, self-control, and critical thinking).[3]

[1] *Brain Architecture*, Center for the Developing Child, Harvard University, available at: https://developingchild.harvard.edu/science/key-concepts/brain-architecture/.

## Toxic Stress

While genes dictate a portion of a child's brain development, according to the Centers for Disease Control and Prevention, healthy brain development also depends on external factors, such as:

- Proper nutrition.
- Exposure to toxins or infections.
- A child's experiences with other people and the world.[4]

[2] Sarah Cuskick and Michael Georgieff, The *First 1,000 Days of life*: The Brain's Window of Opportunity, UNICEF Office of Research, available at: https://www.unicef-irc.org/article/958-the-first-1000-days-of-life-the-brains-window-of-opportunity.html.
[3] Ibid.
[4] *Early Brain Development and Health*, Centers for Disease Control and Prevention, available at: https://www.cdc.gov/ncbddd/childdevelopment/early-brain-development.html.

Accordingly, the interaction between a child and its parents and caregivers is critical. In fact, without appropriate engagement by caregivers, a child's brain can activate its stress responses.[5] Stress is an important chemical response that empowers humans to avoid and react to dangerous situations. However, for children who experience abuse, neglect, parental substance use, or hunger, their brains' stress responses may not shut off appropriately, which can result in toxic stress. Toxic stress is the "unrelieved activation of the body's stress management system in the absence of protective adult support."[6]

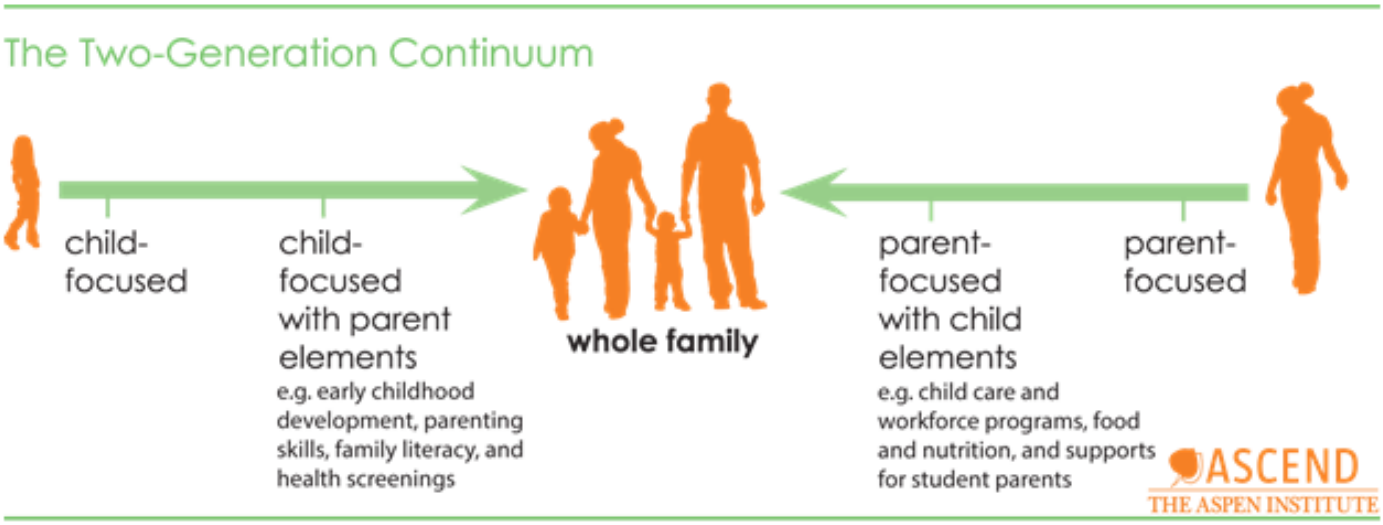
Toxic stress has lasting implications for those who experience it. Research has shown that long-term production of stress chemicals can suppress a person's immune system, resulting in greater susceptibility to infection and disease. It can even change the architecture of a person's brain, especially in the regions that manage learning, memory, emotion, and higher-order thinking.[7] Without responsive caregiving, a child may experience physical, emotional, and mental delays that can last a lifetime.[8]

Building supportive environments for children, even those who have experienced toxic stress, can decrease the likelihood of adverse outcomes.[9] Evidence-based home visiting can work with parents and caregivers to build supportive environments that promote healthy growth and development for children. Home visiting programs can also work with parents and caregivers to address their own trauma—whether they experienced it as children or adults—that holds them back in their personal and professional lives.

## Two-Generational Approaches

Home visiting is a two-generational approach, or one that focuses "on creating opportunities for and addressing needs of both children and the adults in their lives together."[10] Evidence-based home visiting provides families with the education and supports they need to be their child's first and best teachers, such as strategies to promote proper brain development, physical development, and kindergarten readiness. These programs also have prescribed curricula to help parents improve their own health, set goals, and overcome challenges.

Two-generational approaches maximize the state's investment by addressing the needs of both children and the family units in which they live. Children don't exist in a vacuum. Often, their needs are affected by the needs of their parents. Accordingly, to ensure children have the strong foundation they need for lifelong success, they must be rooted in strong families.




[5] Ibid.
[6] *Toxic Stress Derails Healthy Development*, Center for the Developing Child, Harvard University, available at: https://developingchild.harvard.edu/resources/toxic-stress-derails-healthy-development/.
[7] National Scientific Council on the Developing Child (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3*. Updated Edition. Retrieved from www.developingchild.harvard.edu.
[8] *Brain Architecture*, Center for the Developing Child, Harvard University, available at: https://developingchild.harvard.edu/science/key-concepts/brain-architecture/.
[9] National Scientific Council on the Developing Child, *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3*, at page 4.
[10] What is 2Gen, The Aspen Institute, available at: http://ascend.aspeninstitute.org/two-generation/what-is-2gen/.

## Return on Investment

As Ohio positions itself to address current and future workforce shortages, evidence-based home visiting can be a powerful tool to tackle both. According to the Aspen Institute, "investments in high-quality early education yield a 7 to 10 percent per year return on investment" from reduced social costs and increased academic and career performance.[11]

Because the state of Ohio only invests in evidence-based programs – defined as interventions that "produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal" – possible outcomes are well-documented and include:

- Improved birth outcomes, such as increased birth weight and full-term births.
- Reduced parenting stress and substance use.
- Increased parent understanding of their child's development and helping them reach critical milestones.
- Improved academic performance and kindergarten readiness for children.[12]

In fact, every dollar invested in certain evidence-based home visiting programs produces $5.70 in return.[13]

The advisory committee often heard from families who have received home visiting services. One mother, who became pregnant as a teenager, knew little about child development or what she wanted from her own future. She attributes the fact that she graduated from high school and college and now serves as a home visitor herself, to the support and coaching of her home visitor. When she experienced homelessness during her second pregnancy, her home visitor worked with her to find housing and encouraged her to complete college. She completed her degree and now serves as a home visitor, bringing that same passion and compassion to the families she serves. Her children are also healthy, thriving, and succeeding academically.

When families open their doors to evidence-based home visiting, the outcomes are remarkable.

[11] Ibid.

[12] Ohio invests in three evidence-based home visiting programs, including: Parents as Teachers, https://parentsasteachers.org/results-evidence-based-home-visiting-model; Nurse Family Partnership, https://www.nursefamilypartnership.org/wp-content/uploads/2019/02/OH_2019-State-Profile.pdf; and Healthy Families America, https://www.healthyfamiliesamerica.org/impact-briefs.

[13] *2019 State Profile: Ohio*, Nurse Family Partnership, available at: https://www.nursefamilypartnership.org/wp-content/uploads/2019/02/OH_2019-State-Profile.pdf.

# Ohio's Home Visiting Programs

Ohio provides home visiting services through many state and local agencies, including the Ohio Department of Developmental Disabilities, the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Commission on Minority Health, and the Ohio Children's Trust Fund.

Ohio's largest home visiting program—Help Me Grow—is jointly administered by the Ohio Departments of Health and Developmental Disabilities. The Ohio Department of Health administers the state's evidence-based home visiting program for at-risk children and families, while the Ohio Department of Developmental Disabilities administers the state's Early Intervention program for children with developmental delays.

## Ohio Department of Health

About 140,000 pregnant women and young children are considered eligible for evidence-based home visiting services. To be eligible, families must have income at or below 200 percent of the federal poverty level and meet one of the following criteria:

- A pregnant woman under age 21.
- A previous preterm birth.
- A history of child abuse, neglect, or interactions with child welfare.
- A history of substance use or those that demonstrate a need for substance use treatment.
- A child who has a diagnosed developmental delay.
- Tobacco users.
- An active duty military member.
- A history of unstable housing or homelessness.
- A caregiver who has a history of depression or other diagnosed mental health concerns.

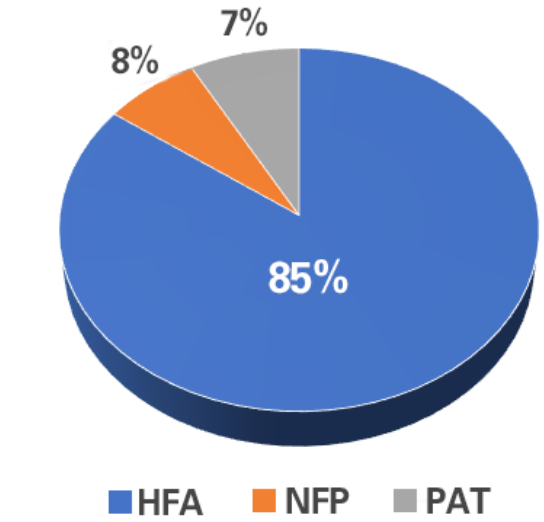
Ohio is currently serving just 6 percent of eligible families – or 8,915 families – through its evidence-based home visiting models. Ohio uses three models, which are detailed in the following graphic, to provide home visiting services to at-risk children and families. An additional 1,865 families are served through Moms & Babies First, a home visiting program focused on black families.

Nurse-Family Partnership (NFP) is designed for first-time, low-income pregnant women and their families. Women must enroll in NFP early in pregnancy and receive their first home visit no later than the end of her 28th week of pregnancy. The model deploys registered nurse who possesses a Bachelor of Science in nursing to women's homes to conduct the visits. Children can be served by NFP up to their second birthday. In 2018, 715 families received home visiting through NFP.


Healthy Families America (HFA) is designed for parents facing challenges such as single parenthood; poverty; a childhood history of abuse and other adverse child experiences; current or previous issues related to substance abuse and mental illness; and a history of domestic violence. Women can enroll in HFA prenatally or within three months of their child's birth and remain in the program until their child's third birthday. In 2018, roughly 7,500 families received HFA home visiting services.

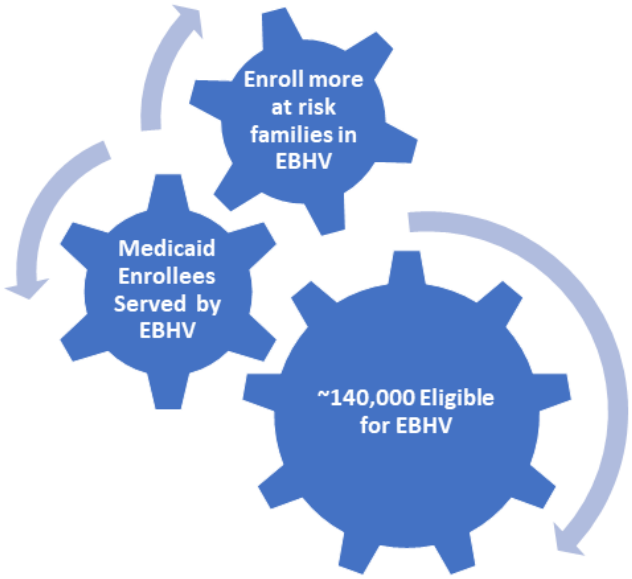
The Parents as Teachers (PAT) program has four primary goals: increase parent knowledge of early childhood development and improve parenting practices, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness and success. While the PAT model can be used for children from prenatal to kindergarten, the Ohio Department of Health requires that most families enroll prenatally or within six months of their child's birth, and families can remain in the program until their third birthday. In 2018, approximately 700 Ohio families received home visiting services through PAT. The Ohio Children's Trust Fund invests additional state-funding to support Parents as Teachers programming.

**Percentage of Home Visiting Families By Model**

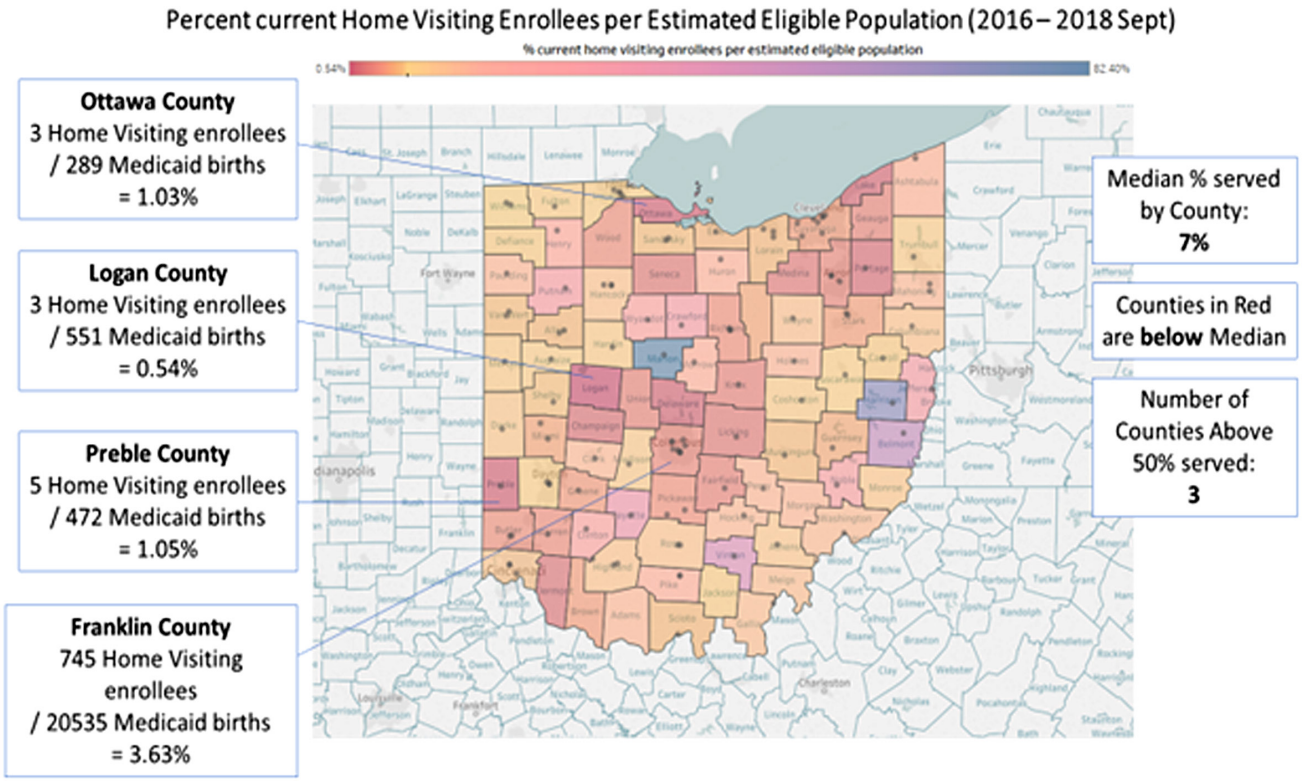



The above programs are delivered by 106 contracted providers in 82 Ohio counties. Six Ohio counties lack a home visiting provider, demonstrating that the state must increase its home visiting provider options.

Just over half of all Ohio births in 2016 were to Medicaid-eligible families.[14] Pregnant women up to 200 percent of federal poverty level are eligible for Medicaid, indicating that many women whose births were covered by Medicaid may be eligible for evidence-based home visiting services, yet just a fraction of these families are served through home visiting.




[14] *Report on Pregnant Women, Infants and Children*, Ohio Department of Medicaid, Dec 29, 2017, available at: https://medicaid.ohio.gov/Portals/0/Resources/Reports/PWIC/PWIC-Report-2017.pdf?ver=2017-12-29-112608-887, 4.




## Ohio Department of Developmental Disabilities

The Ohio Department of Developmental Disabilities, in conjunction with county boards of developmental disabilities, served more than 22,000 children with Early Intervention services in 2018. Early Intervention services are available in all of Ohio's 88 counties, and eligible children receive services immediately, as waitlisting is prohibited by federal law. Children are eligible to receive Early Intervention services if they demonstrate:

- Categorical eligibility due to a diagnosed condition that has a high probably in resulting in a delay or disability, such as:
    - Very low birth weight.
    - Chromosomal conditions.
    - Neurological conditions.
    - Fetal Alcohol Syndrome.
    - Lead poisoning of 5 micrograms per deciliter or more.[15]
- A diagnosed condition that has a high probability in resulting in a delay or disability by a physician or other licensed professional.
- A developmental delay of at least one and one-half standard deviations below the mean in one of the developmental domains—adaptive, cognitive, communication, physical, or social-emotional—as determined and documented by the "Bayley Infant Scales of Development" or the "Battelle Developmental Inventory."[16]

Of the 22,000 children served by Early Intervention services, 86 percent were made eligible via a delay in at least one of the five enumerated developmental domains. More than 60 percent had a significant delay, meaning two or more standard deviations, in at least one of the five enumerated domains. The remaining 14 percent of children were made eligible because the child had a diagnosis likely to result in a developmental delay, such as autism, cerebral palsy, or hearing loss.

Ohio remains somewhat below the average for young children (ages 0-3) served by Early Intervention services. In states with comparable Early Intervention eligibility requirements, 3.26 percent of children were served, whereas Ohio serves just 2.53 percent of children. The Ohio Department of Developmental Disabilities is obligated to engage in child find efforts. By increasing these efforts, and making changes to the Ohio Administrative Code to add two new eligible diagnoses (blood lead levels of 5 micrograms per deciliter or higher and neonatal abstinence syndrome), the Ohio Department of Developmental Disabilities can increase the number of families and children served by Early Intervention services.

[15]OAC § 5123-2-10-01 (note that lead poisoning will become eligible for early intervention services beginning on July 1, 2019).
[16]OAC 5123:2-10-01(B)(7)(a)-(c).

The Ohio Department of Developmental Disabilities has agreements with 80 local agencies to provide Early Intervention service coordination, evaluation, and assessment. County boards of developmental disabilities provide about 95 percent of Early Intervention services that can include:

- Special instruction.
- Occupational therapy.
- Speech therapy.
- Physical therapy.
- PLAY project coaching.

Families in Early Intervention are better able to meet their children's developmental needs, and data suggests that Ohio's Early Intervention program generates cost savings to the state through reduced need for Individualized Education Plans and additional services in the K-12 system. In state fiscal year 2018, for children served for at least six months by Early Intervention services:

- Well over half of children who entered the program below age expectations improved their development enough to move closer to their typically-developing peers.

- As many as 68 percent of children were functioning at age expectations upon exit from the program.

## Ohio Department of Medicaid

The Ohio Department of Medicaid is committed to improving maternal and child health and invests in programs designed to promote positive outcomes for both populations, beginning with high-quality prenatal care for expecting mothers.

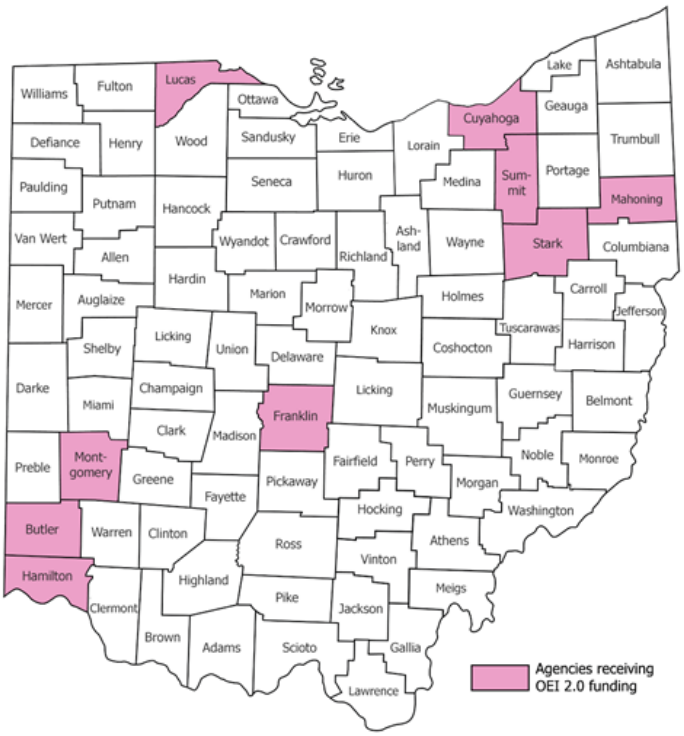
For Ohio's most in-need pregnant women, the Ohio Department of Medicaid provides maternal care management through the managed care plans, to identify and provide services to all women at risk for poor birth outcomes. The managed care plans support families and women by arranging for timely, evidence-based services. To meet their enhanced maternal care requirement, the Medicaid managed care plans contract with evidence-based home visiting programs; Community HUBS; and collaboratives like the Ohio Perinatal Quality Collaborative and other community efforts to stop infant mortality in the nine counties with the highest rates of infant deaths in Ohio.

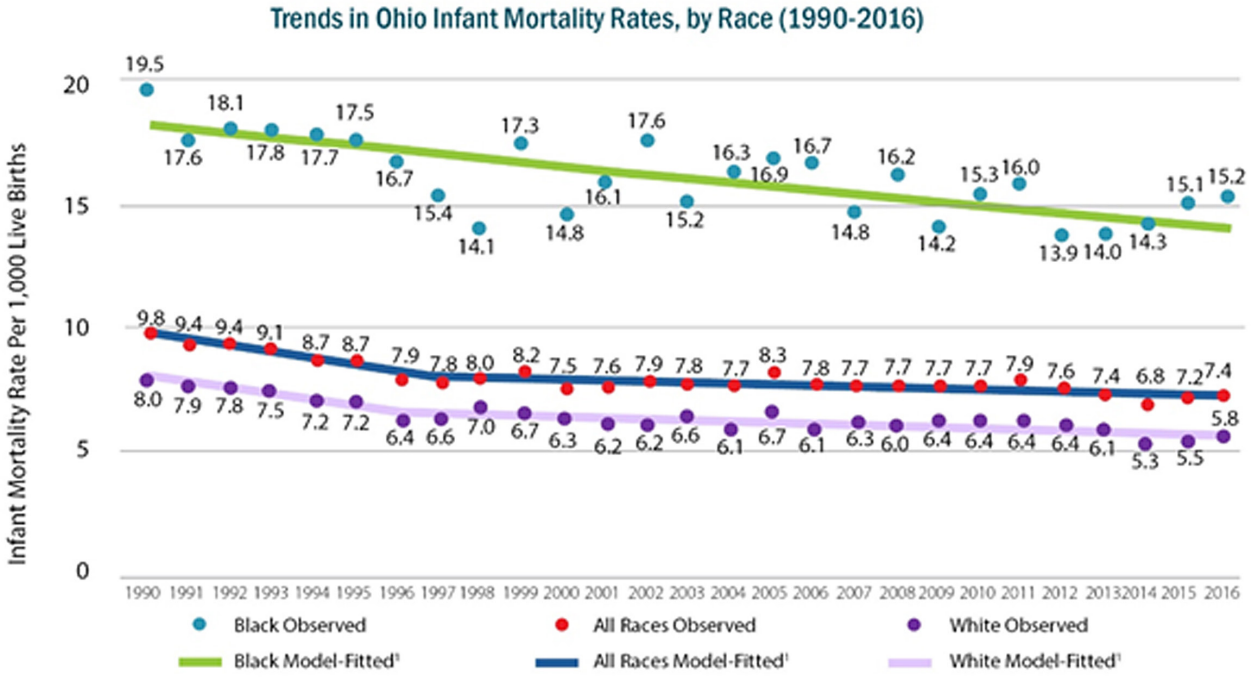
Home visiting is one of the Department of Medicaid's most critical strategies for reducing infant mortality and promoting family and child health. Medicaid managed care plans arrange for home visiting programs designed to improve health outcomes; child development; school readiness; parenting skills and strategies, including connections and referrals to supports; and family self-sufficiency. As a result, in part, of the Ohio Department of Medicaid's investment in home visiting, Ohio has seen fewer preterm births and fewer and shorter stays in neonatal intensive care units.

This year, the Ohio Department of Medicaid will serve almost 2,000 families through evidence-based home visiting programs – including Nurse Family Partnership – and other strategies, such as Moms & Babies First, doulas, CenteringPregnancy, and Growing Great Kids. The total Medicaid investment in these home visiting programs is more than $8.6 million. Almost $6 million in additional state funding flows to Community HUBs through the Ohio Department of Medicaid and Ohio's Commission on Minority Health. These funds will connect 10,000 women and their children to a medical home and other supportive services.

In 2016, two depression screening codes for mothers were added to the types of screenings that could be reimbursed through Medicaid. These screenings for new mothers can take place during a baby's well-child visit or during a home visit. Because of this change, the number of maternal depression screenings conducted in Ohio has increased dramatically, from just over 90,000 in 2016 to almost 130,000 in 2018. Through screening and referral for services, the Ohio Department of Medicaid is helping families overcome the barriers to bonding that maternal depression can create.

Despite collaborative efforts among the Ohio departments of Health and Medicaid, infant mortality rates in the state remain among the highest in the nation, especially for black babies. Governor Mike DeWine has committed to expanding evidence-based home visiting services to help three times as many Ohio families as were previously being served. Evidence-based home visiting is an effective tool to combat infant mortality, improve kindergarten readiness, and promote the strength of families.






*Source: Ohio Department Of Health, Bureau Of Vital Statistics.*

*[1] "Model-Fitted" Definition – Joinpoint software models were used to test the statistical significance of changes in trends. For each group the best fitting trend lines are presented. A change in trend was observed for all races infant mortality in 1996 and for white mortality in 1997. No change in trend was detected for black infant mortality.*

# Recommendations

In response to the state's broad investments in evidence-based home visiting and other evidence-informed strategies for improving outcomes for children and families, the Governor's Advisory Committee on Home Visitation developed the following recommendations to improve the delivery of Ohio's home visiting services. Unless otherwise specified, the following recommendations apply only to the Ohio Department of Health's evidence-based home visiting programs, delivered through Help Me Grow, that serve at-risk pregnant women and young children.

The following recommendations will aid the state in tripling the number of families served through evidence-based home visiting.

To eliminate disparities, the committee suggests that the state:

## 1) Make race and ethnicity foundational elements of the state's infant mortality efforts.

While statewide infant-mortality reduction efforts have resulted in fewer babies dying before their first birthday, black babies continue to die at nearly three times the rate of their white peers. Accordingly, race, ethnicity, and a strong focus on racial disparities must be central to the state's ongoing infant-mortality reduction efforts. The state should regularly report on the disparity and impact that social determinants, such as housing, can have on infant mortality. All state agencies that invest in home visiting—including the Ohio Department of Health, the Ohio Department of Medicaid, and the Commission on Minority Health— should use the reports to reevaluate their infant mortality strategy and investments.

To engage and enroll families, the committee suggests that the state:

## 2) Expand and streamline eligibility requirements so more at-risk families can be served.

Any family under 200 percent of federal poverty level should be eligible for voluntary services through Help Me Grow, and black mothers of all ages should be eligible for Moms & Babies First. The state should consider including home visiting services in the array of benefits accessible through the Ohio Benefits portal.

## 3) Improve the way children involved with the child welfare system are connected to home visiting services.

Federal law requires all children with a substantiated case of abuse or neglect and those identified as affected by illegal substance abuse or withdrawal symptoms from prenatal drug exposure to be referred to Help Me Grow Early Intervention services provided through the Department of Developmental Disabilities. Many of these children may not require Early Intervention services but would benefit from home visiting. The Ohio Department of Health and the Ohio Department of Developmental Disabilities should work together to enhance the process for triaging child welfare-engaged children and linking those who are not eligible for Early Intervention services to the Ohio Department of Health's Central Intake, with parent permission.

## 4) Ensure children up to age 3 can enroll in a home visiting program.

The Ohio Department of Health provides home visiting services through three evidence-based models. Two of Ohio's models have limitations on the gestational period of the mother and ages of children who can enroll. Nurse-Family Partnership's model requires enrollment no later than the end of the women's 28th week of pregnancy, while Healthy Families America enrolls women prenatally or children within three months of birth. The state should ensure that children between the ages of 4 months and 3 years, who are otherwise eligible for home visiting services, are served by Parents as Teachers or another model approved by the Department of Health.

## 5) Implement a targeted recruitment campaign for families.

Some women may feel stigmatized for receiving evidence-based home visiting services. The state should invest in an educational campaign, targeted to eligible families, that shares the benefits of enrolling in evidence-based home visiting services.

## 6) Use a risk-based tool to refer mothers to home visiting.

The state should use the electronic Pregnancy Risk Assessment Form (PRAF) for all pregnant women, to identify high-risk mothers and refer them to evidence-based home visiting programs. All providers should use the web-based PRAF, which automatically connects to county departments of Job and Family Services to maintain Medicaid coverage for a woman during her pregnancy. All payers should accept the standard PRAF form. The use and sharing of the PRAF must comply with the Health Insurance Portability and Accountability Act and other state and federal privacy laws.

## 7) Create a central point of intake for all home visiting programs.

A coordinated state system of home visiting requires a single point of entry for all programs. All home visiting providers—including evidence-based, evidence-informed, and promising programs funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children's Trust Fund, and the Commission on Minority Health—should use the state's central intake system as their primary referral source. The system will connect families to all state-funded models of home visiting, based on eligibility, medical and social risk, and family choice. The system should minimize the of duplication of services. State agencies should work together to share data and ensure home visiting services are provided across systems.

## 8) Create a central data warehouse for all home visiting programs.

All home visiting providers— including evidence-based, evidence-informed, and promising programs funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children's Trust Fund, and the Commission on Minority Health—should use the state's home visiting data warehouse, Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS). The director of Children's Initiatives should work with the Ohio Department of Health and other appropriate state agencies to ensure data is interoperable with existing data management systems and that data is accessible and able to be extracted by providers and relevant state agencies.

To improve programming, the committee suggests that the state:

## 9) Expand the Ohio Department of Health's goals and performance standards to include social determinants of health.

The Ohio Department of Health should expand the goals of home visitation and develop robust outcome measures for each goal to ensure home visitation programs are positively addressing each one. The Ohio Department of Health should consult with the Ohio Department of Medicaid and other involved parties when developing its outcome measures. Existing goals for home visitation are: improving maternal and child health, preventing child abuse and neglect, encouraging positive parenting, and promoting child development and school readiness. The Ohio Department of Health should add two additional goals: reducing infant mortality and addressing social determinants of health.

## 10) Promote collaboration among health care payers, children's hospitals, birthing hospitals, and other community-based providers.

It is essential for payers, children's hospitals, birthing hospitals, and community-based providers to be resources to the state and local implementing agencies. They should serve as a link to evidence-based home visiting and Early Intervention programs. Hospitals should also consider providing back-office support, Medicaid billing, and evaluation and data-science backing to improve programming within the local implementing agency.

## 11) Ensure portability of eligibility across models, providers, and geographical boundaries.

Families may lose their eligibility for home visiting services if they switch between programs, move across counties, or change among the three models. Families should categorically retain their eligibility regardless of these changes and during brief hiatuses from the program due to illness or other issues.

## 12) Publish regular, transparent reports on home visiting programs and outcomes.

The Office of Children's Initiatives will convene state agencies to identify standard benchmarks and performance and outcome measures for all state-funded home visiting programs, including those funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children's Trust Fund, and the Commission on Minority Health. All state agencies that fund home visiting programs shall regularly participate in data sharing and reporting based on the standards set by the Office of Children's Initiatives. The Office of Children's Initiatives should issue regular reports that include this data.

When it comes to paying for home visiting, the committee suggests that the state:

## 13) Ensure provider payments and reimbursement rates are adequate, tied to the skill level of the home visitor, fund the supervision required, and enable providers to expand their programs.

The Ohio Department of Health should perform a market analysis and conduct a historical data review to determine its provider payment structure and reimbursement formula to ensure that rates are tied to the skill level and education of home visitors; account for administrative costs, including supervision; and enable providers to expand their programs.

## 14) Leverage the Medicaid program to reimburse for eligible services in a more cost-effective manner.

The Ohio Department of Medicaid, in collaboration with the Ohio Department of Health, should investigate all options for using Medicaid funding to support home visiting services. The Ohio Department of Medicaid should develop its strategy and implement it within a reasonable amount of time.

## 15) Align the Department of Medicaid infant mortality reduction funds to complement the Help Me Grow program.

The Ohio departments of Medicaid and Health should work together to ensure that all state-funded home visiting programs are aligned and targeted to reduce infant mortality in Ohio's highest incidence communities. The state departments should identify common outcomes measures and accountability standards for local implementing agencies. The state departments will also encourage collaboration among local implementing agencies so that state dollars are used effectively and to complement existing programming.

## 16) Increase the frequency of the Ohio Department of Health's incentive payments.

Evidence-based home visiting providers receive annual "incentive" payments for achieving specific metrics set by the Ohio Department of Health. Providers often do not know if they will receive incentive payments or the amount of their incentive payments, which affects their ability to plan future programming. The Ohio Department of Health should investigate increasing the frequency of incentive payments, so agencies are better able to plan, hire staff, and expand programming.

## 17) Execute an Ohio Return on Investment Study of home visiting programs.

To ensure Ohio is achieving the best outcomes for families with its home visiting investments, the state agencies supporting home visiting and infant mortality reduction efforts—including the Ohio Department of Health, the Ohio Department of Medicaid, and the Commission on Minority Health—should execute a Return on Investment study. The study should explore regional, local implementing agency, and model levels with the goal of improving health outcomes and health value.

To bolster the workforce needed to provide home visiting services, the committee suggests that the state:

## 18) Match the education level or credential requirement to the evidence-based home visiting model.

Ohio requires that home visitors have at least an associate degree, but Ohio's most widely used evidence-based home visiting program—Healthy Families America—requires only a high school diploma. The state should remove the associate degree requirement and match the standards set by each evidence-based home visiting program. Local implementing agencies may continue to require education levels above the model standards.

## 19) Provide professional development that promotes cultural competence among home visitors.

The Department of Health should develop and deploy professional development programming for all home visitors and supervisors on implicit bias, cultural responsiveness, trauma-informed care, and identifying maternal depression. This training should be free to all state-funded home visiting providers, including those funded by the Ohio Department of Health, the Ohio Department of Medicaid, the Ohio Children's Trust Fund, and the Commission on Minority Health.

## 20) Create career pathways for home visitors.

As a corollary to reimbursing evidence-based home visiting services based on the skills and education of the home visitor, the Department of Health should establish a career pathway for home visitors that is aligned with the state's Career Pathways Levels.

Recommendations of the

# Governor's Advisory Committee

on

# Home Visitation

***March 2019***

Children's Initiatives
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